MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

March 10, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, March 10, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Bob Atwater, Doug Berger, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representative Van Braxton and Representative William Brisson were present. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the February 10, 2010 meeting. The motion was made by Representative Earle and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS), provided a brief update on current issues relating to funding programs within DHHS. Limitations on the availability of funds continue to create problems. Most recently, DHHS had to find $7M to cover a shortage of funds in the Aids Drug Assistance Program. According to the Secretary, there is enough money to cover expenses through this fiscal year but additional funds will have to be appropriated to meet the need next year. Also, Medicaid continues to be over budget. Medicaid is a federal/State program and any changes to the program must be approved by the federal government. Finally, the Secretary noted that the Governor is making Program Integrity a top priority. Before services are cut or reduced there will be an effort to see that services are appropriate and that services are not being abused or fraudulently accessed in the system.

Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, provided details on expanding the 1915 (b)(c) Waiver to other local management entities. (See Attachment No. 2) Interesting points included:

- Waivers are requests to CMS that exempt operators of the waiver from certain requirements of the Social Security Act, this could include such requirements as

State wideness or the "any willing and qualified" provider provisions. Services must be managed in a cost neutral manner.

- The 1915 (b) waivers or "freedom of choice" waivers deal with managed care, 1915 (c) waivers are for Home and Community Based Services in lieu of institutional care. An example of this is our current CAP-MR/DD waiver.
- PBH formerly Piedmont Behavioral Health began operating under two waivers as a pilot project in 2005 for Medicaid funded services for MH/DD/SA on a capitated basis in the LME's catchment.
- Based on the performance of PBH and with guidance from the LOC and the General Assembly, DHHS has elected to expand the pilot beyond PBH.
- In 2009, DHHS submitted a waiver amendment to CMS designed to expand the pilot project through a modification of the existing PBH waivers. The Waiver Amendment has been approved.
- Interested LMEs that meet qualification criteria can apply for consideration by April 14, 2010 with a planned start up date of January 1, 2011.
- Operating under the 1915 (b)(c) Waiver allows a LME the opportunity to combine the utilization of State and Medicaid dollars at the community level.
- There are 6 LMEs that currently meet the criteria for 70,000 covered lives for the Waiver – Smoky Mountain, Western Highlands, Mecklenburg, Sandhills, CenterPoint, and Piedmont.

Several members expressed concern that the small to medium size LMEs would not be able to meet the criteria for the 70,000 population and that they could be put out of business due to the changes. Mr. Watson assured members that different options were available and that DHHS was trying to operate with as much flexibility in the process as possible in order to build on a firm foundation.

During questions about the waiver expansion, the issue of CABHAs and how consumers would be transitioned came up. Secretary Cansler stated that the process of how to transition consumers would begin on April 1. LMEs would work with providers that have not applied to become a CABHA. If an agency wishes to be certified as a CABHA July 1, they must apply before April 1. If an agency has not submitted a letter for attestation and they deliver one of the three services (Intensive Home, Day Treatment or Community Support Team) required to be classified as a CABHA, the transition of consumers would need to take place in order to see that services are not interrupted. He said the idea is to have a more clinically founded system. DHHS is in communication with CMS to see if there is some flexibility in the transition process. Representative Insko requested that members forward emails with concerns regarding the system to DMH in order for them to respond during the meeting on April 14th.

Dan Coughlin, Area Director and CEO of PBH and Pam Shipman, Chief Operations Officer, provided a detailed presentation of a Medicaid Waiver and a Managed Behavioral operating model. (See Attachment No. 3) They addressed how PBH is structured, how it operates, the effect on the community, the budgetary concerns and the quality of care for consumers. Additional points highlighted in the presentation included:

- The goal of Managed Care is to manage cost, manage limited resources, develop parity and match needs to services.
- Detailed data provides a connection between need, services, and cost enabling PBH to coordinate a managed system.
- Grievances are tracked and resolved within 30 days.
- Skill mapping software allows PBH to look at locations of consumers and providers. CMS requires that services be available within 30 miles/30 minutes. Important tool used in operating and enrolling providers in the PBH network.

Arthur Carder, CEO of Western Highlands Network (WHN), Jennifer Wehe, Executive Director of Access II Care of Western North Carolina, and Dr. Richard Hudspeth, Medical Director of Access II Care, provided a presentation on Community Care of North Carolina (CCNC) and LME integrated care. Mr. Carder pointed out that the National data shows that consumers with severe mental illness die 25 years sooner than the general public. He also said that partnerships have been formed between LMEs and CCNC to save the lives of consumers, to improve their quality of life, and to facilitate the use of limited resources – staffing and funding.

Ms. Wehe stated the following facts during her presentation:

- CCNC is a volunteer network of physicians, hospitals, health departments, local counties Department of Social Services and LMEs. Statewide there are 14 networks which include 4,000 physicians in all 100 counties and 990,000 Medicaid enrollees. Access II Care manages care for over 50,000 Medicaid enrollees.
- A Mercer analysis in FY 2007 indicated that CCNC saved tax payers of North Carolina between one hundred and thirty five million ($135M) and one hundred and forty nine million dollars ($149M).
- CMS recently awarded North Carolina a 646 Federal Demonstration Waiver allowing Community Care to expand strategies in the Medical Home model to the dually eligible and Medicare patients. As a precursor to the 646 Waiver, the network has expanded the focus to include Care Management programs for the complex chronically ill, aged, blind and disabled population. This population equals 20% of the Access II Care enrollees and 80% of the total Medicaid dollars spent.
- 47% of the total Medicaid cost for Access II Care is attributed to MHDDSA services.

Dr. Hudspeth also made the following points:

- Every system is perfectly designed to get the results it achieves. The current system is designed to fit within our cultural model and the results are products of that model. There is a mind/body silo with physical care in one place and mental care in another. The people in the silos do not communicate very well. An internal chart audit of primary care providers indicated that only 2% of the time showed there was information in the chart regarding the mental care provider.
- An example of one case provided an illustration of the short comings of the system and the potential for heightened collaboration between the LMEs and the

Community Care network. In the end, the inpatient utilization was reduced by 64%, MH/SA hospitalization by 25%, and ED utilization by 55%. The difference was the right care - all the members of the care team including the patient getting the right resources to the patient; right communication – relationship building between all team members, sharing information and data; and using the dollars to reduce cost and achieve better outcomes.

Secretary Cansler requested a road map for this project, to create a timeline for further implementation with the needs and further develop the cost saving analysis.

Joel Corcoran, Director of the International Center for Clubhouse Development (ICCD), explained what a Clubhouse is and how the ICCD organization operates to improve the life circumstances of people living with serious mental illness. (See Attachment No. 5) He said there were 334 member Clubhouses and 25 new start-up working groups in more than 30 countries. His presentation included the following points of interest:

- A Clubhouse is more than a program or a service or a contract with DHHS. It is a community of people intentionally designed to help people come together and to support each other while living with and overcoming the circumstance of mental illness.
- A Clubhouse is a membership organization and members have ownership and responsibilities for what goes on there.
- Clubhouses are organized around 36 internationally recognized and established Best Practices.
- Clubhouses are open to those 18 years and older with a diagnosis of a serious mental illness. The operation of the Clubhouse during the day include clerical duties, reception, food service, transportation, program management, outreach, managing the employment education program, managing the financial services, advocating for services with mental illness and more.
- Members and staff do all the work together in the Clubhouse side-by-side.
- Clubhouses are different than other PSR programs. Key differences – 60 years in refining and practicing the model; Evidence Based Practice; structured standards training and network of peer support for Clubhouses; and Clubhouse certification accreditation.

Next, Charlene Lee, a member of Club Nova, an ICCD Certified Clubhouse Model, provided the Committee with a testimony of her life and told of the profound effect Club Nova has had on her life. (See Attachment No. 6) Ms. Lee described how Club Nova helped her secure a job, find an apartment, enroll in Medicaid to help pay for medications and how she was approved for full disability with the help of staff. She concluded her speech by asking for support of the existing Clubhouses saying they were cost effective and a wise investment of public funds.

Dr. Sue Estroff with the School of Medicine, UNC, explained why there needs to be a Clubhouse specific service definition. (See Attachment No. 7) Her presentation included the following points of interest:

- Universities and community colleges benefit from teaching, training, and skills of Clubhouses. Social work students, nursing students, business students, and others train at Clubhouses.
- Clubhouses are already providing community support services as defined in administrative rules.
- Last year, Threshold provided over $137,000 in uncompensated care to members who lost county based funding and did not qualify for Medicaid. Overall, the Clubhouses in North Carolina gave $766,000 in uncompensated care because of the way the rates are established and because of the way the service definitions are written. Clubhouses are not able to continue with these expenditures without help.
- Between 1998 and 2009 the rates paid under the service definition increased $2.95. Clubhouses provide community support service and would like to be paid for what they are providing.
- Implementation of CABHA will result in the demise of Clubhouses in North Carolina.

Jackie Combs, a Clubhouse director and executive director of a non-profit mental health agency in Henderson County, read the 4 recommendations requested by the Clubhouse Coalition. (See Attachment No. 8)

Secretary Cansler said that because of the financial stability concern for the Clubhouses, he had recently requested Mike Watson and Leza Wainwright to recommend a way to adjust the rates to make the Clubhouses financially sustainable. He added that the Clubhouses are an important part of the continuum of care and DHHS is trying to identify funds to help. Secretary Cansler said he would follow up on the issue of a new service definition.

Rob Lamme, Consultant and former Director of Government Relations with DHHS, presented a proposal designed to help communication between the university system and the mental health system (See Attachment No. 9). Mr. Lamme described the Policy Hub as a place in the Keenan Flagler School of Business where those in the MHDDSA system, the University system and stakeholders in MHDDSA within the University system can collaborate. Formerly the Mental Health Leadership Academy (MHLA) was a program funded by the General Assembly that operated to provide leadership and management training for the LME system, but was disbanded last year largely due to the budget crisis. Despite the current economic picture, Mr. Lamme believes there is still a need for collaboration to apply for federal and private grants that cross agencies that could provide critical services and pilot programs for the system. The Hub could utilize the University's ability to find and obtain grants not only for the University system but also for the MHDDSA system. The Hub could help graduate and undergraduate students obtain experience in the MHDDSA system that is currently difficult to access. The Hub would be the portal into the University system to access resources. Mr. Lamme requested that the Committee consider recommending funding for the Hub to the General Assembly.

Tara Larson, Chief Clinical Operating Officer, DMA, reported on case management consolidation. (See Attachment No. 10) Points of interest included:

- Diagram illustrates what case management would look like in the future. Services are building off the CABHA as well as the 1915 (b)(c) waiver, and the integrated approach through CCNC.
- Workgroups are meeting in order to strategize on case management services consolidation.
- DMA requires linkages between primary care and behavioral health on all of the waiver implementation and the RFA. Through linkages and the workgroups, major triggers have been identified to establish better communication and coordination of care.
- Workgroup for forms standardization is looking at how computer systems can provide the same information rather than a particular block on a form.
- Short term goal - looking at ways to address costs associated with case management since that is a condition with consolidation.
- Unit limit has been established and went into effect March 1 requiring a reduction of 3 hours per month with an additional 6 hours that can be used for crisis.
- Prior authorization of CAP MR/DD case management has been eliminated which went into effect March 1. This will reduce some of the administrative burden on providers.
- Effective April 1, an edit has been placed in the system reducing the number of case managers in order to have single case managers dealing with families and consumers in order to eliminate confusion in the care of a recipient.

Andrea Stevens from the Services Task Team of the State Consumer Family and Advisory Committee (SCFAC), said that their efforts focused on service gaps and underserved populations; making recommendations regarding the service array; monitoring the development of additional services; and to participate in all quality improvement measures and performances. An outline of the Team's suggestions is attached. (See Attachment No. 11) Representative Insko noted that it was important to have more consumer input. Ms. Stevens commented that the timeliness of that input was important. She said it was imperative to be in the process from the beginning.

Carl Noyes, an eastern North Carolina representative of the SCFAC said there was concern among consumers that CABHAs will not build in areas where there is not enough population to support them and where CABHAs do build they will eliminate the small providers. There is also concern that the small provider may collapse under the tremendous growth that they will experience. He said that SCFAC would like to urge DHHS to slow down the process to allow providers the opportunity to determine how to manage the growth and have the proper infrastructure in place to support that growth. (See Attachment No. 12)

David Cornwell, Executive Director of North Carolina Mental Hope, a consumer-driven advocacy organization, addressed the problem of inclusion regarding collaboration between consumer-driven organizations and DMH. (See Attachment No. 13) He indicated that it was implied that stakeholder inclusion was synonymous with consumer

inclusion but that is not the case since consumers are not stakeholders. He said the State had the opportunity to recognize the equality of all citizens, the opportunity to work together for a better system.

There being no further business, the meeting adjourned at 3:15 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant